DO NOT SEND ANY ADDITIONAL DOCUMENTS TO THE EMAIL ADDRESS OR FAX NUMBER BELOW

INSTRUCTIONS:

1. Complete Part 1 of the form.

2. Attend a preventive health visit with your Provider between 9/1/2014 and 8/31/2015.

3. Provide this form to your Provider and ask them to complete Part 2 and sign at the bottom of the form. Please note: Do not submit Laboratory Reports. Only results reported on this form will be processed. **You may be responsible for any charges as applicable from your Provider as a result of completing this form.**

   Remember, your annual preventive care is covered at 100% if provided by an in-network physician. This means you are not responsible for a copay or coinsurance. Talk to your physician about using one of the following codes to make sure your visit is processed correctly:

99385 – New, Ages 18-39	99395 – Established, Ages 18-39
99386 – New, Ages 40-64	99396 – Established, Ages 40-64
99387 – New, Ages 65 & over	99397 – Established, Ages 65 & over

4. Make a copy of the form for your records. You will be responsible for maintaining a record of this form to ensure you receive the incentive credit for your participation. **Forms must be received by no later than August 31, 2015.**

5. Please be sure the form is complete and legible. Incomplete forms will not be processed. Fax or e-mail securely to:

   - Secure Fax Number: 972-865-8164
   - E-mail Address: form@compassphs.com

Support Services:

Need a physician?

Contact Compass Professional Health Services
katym@compassphs.com or 855-777-0534

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PLEASE COMPLETE WITH BLACK PEN, ALL CAPITAL LETTERS. ● Correct ⊗ Incorrect

This form ONLY must be returned via fax to # 972-865-8164 or via e-mail to: form@compassphs.com

PART 1- To be completed by Eligible Member

REASON FOR SUBMITTING FORM: ○ Annual Physical ○ Biometrics ○ Both

Employer: **City of Frisco**	Employee ID Number: ○ Employee ○ Spouse
First Name:	Last Name:
Last 4 Digits of Member SS#: ○ Male ○ Female	Date of Birth: MM/DD/YYYY
E-Mail Address:	Phone Number:

Are you currently using any tobacco products? (within the last 6 months) Yes ○ No ○

PART 2 - Completed by Provider

(Based on Employer Instructions)

Height:	Feet inches
Weight:	pounds
Waist Circumference:	inches
Blood Pressure:	___/___
Total Cholesterol:	mg/dL
HDL "Good" Cholesterol	mg/dL
LDL "Bad" Cholesterol	mg/dL
Triglycerides	mg/dL
Fasting Glucose(Blood Sugar)	mg/dL

Member Attestation/Authorization:

By submitting this form, I am authorizing my Provider to report my laboratory and biometric results to Compass, as part of my employer sponsored health screening. I authorize my Provider to send the requested results to Compass. I authorize Compass to contact my Provider to validate the results, if necessary as determined by Compass. I understand that any information collected as part of this health screening will be treated as confidential. Individual health information will not be shared with my employer**. If I falsify any information, I may be eliminated from any and all future Wellness Programs.**

I understand that my individual health data will be used by Compass and/or affiliated wellness vendors to:

- Inform me of my health risk and possible actions I can take to live a long healthy life.
- Assist me in satisfying any health program requirements as part of my employer's wellness program including any outreach to me.
- Evaluate the impact of the program.
- Provide my employer aggregate information as part of a group summary report (my individual data will not be disclosed).

Compass Notice of Privacy Practices may be found at http://compassphs.com/about-compass.

Member Signature : _____

Date:
MM/DD/YYYY: _____

Screening Date:	Phone Number:
Address:	
City, State, Zip Code:	
Provider Signature:	Date: